# STATE OF WASHINGTON DEPARTMENT OF LABOR AND INDUSTRIES PO Box 44261 Olympia, Washington 98504-4261

## BILLING INSTRUCTIONS – STATE FUND CLAIMS HCFA – 1500 BILL FORM F245-127-000

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Anesthesiologist, Chiropractor, CRNA, Hospital ER/Professional Services, Laboratories, Naturopath, Osteopathic Physician, Outpatient Pain Management Program, Panel Examiner, Pathologist, Physical Therapist, Physician, Physician Assistant, Physician Clinic, Podiatric Physician, Psychologist, Radiologist

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#### **BILLING INSTRUCTIONS**

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

#### **L&I Provider Account Number Required:**

If you do not have an L&I provider account number, please call Provider Accounts at (360)902-5140 to request a provider application form. This form and several other of the most frequently requested forms can be downloaded from our website at <a href="www.wa.gov/lni/forms">www.wa.gov/lni/forms</a>. You may also request additional forms from your local field service location; a list of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

#### **Billing on Paper Forms:**

Submit charges on the "HCFA-1500" bill form (F245-127-000).

Mail HCFA-1500 bill forms to:

Department of Labor and Industries PO Box 44269 Olympia, Washington 98504-4269

#### Bill Forms – Where and How to get them:

Bills must be submitted on ORIGINAL (not photocopied) HCFA-1500 bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000) for single sheet, or FXXX-XXX-111 for continuous pinfeed).

#### **Billing Electronically:**

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

#### When to Submit Bills:

You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

### When payments are made:

The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries Cashier's Office PO Box 44835 Olympia WA 98504-4835

#### **Limits on Bill Processing:**

Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

#### For Help:

If you have questions about "PAID BILLS", "DENIED BILLS" or "ADJUSTMENT BILLS", please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.** 

If you have questions about "BILLS IN PROCESS", please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the "zero" option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any 'wait time' is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

### REPORTING REQUIREMENTS

#### DO NOT ATTACH REPORTS TO THE BILLS

The following required **reports** and **documentation** must be sent separately from your bills in order for them to be routed to the proper department and placed in the proper file:

- a. Consultation reports
- b. Laboratory and X-ray reports
- c. Special reports and/or narratives to support level of office visit or procedure
- d. Operative reports/anesthesia records
- e. Periodic office notes
- f. Periodic chart notes

The injured workers' name and claim number must be placed in the upper right corner of <u>each page</u> on any correspondence or report.

The cost invoices for supplies furnished are not routinely required to be mailed to the department, but may be requested in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Send all reports and documentation for State Fund claims to:

Department of Labor and Industries PO Box 44291 Olympia WA 98504-4291

#### PROVIDER SPECIFIC INSTRUCTIONS

#### **Anesthesiologist**

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Modifiers

CPT Modifiers: -23 & -99

HCPCS Modifier: -AA, -QK and -QY

Anesthesiologists must have valid individual L&I provider account numbers to be paid for services. The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Non-covered codes are listed in Appendix E of the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Anesthesia services paid with base and time units must be billed using CPT anesthesia codes 00100 through 01999 or ASA codes 01951 and 01952. Refer to "Anesthesia Services Paid with Base and Time Units" in the Anesthesia Payment Policies section in the current Medical Aid Rules and Fee Schedules.

Effective for dates of service on or after July 1, 2000, anesthesia reimbursement will be calculated using 15-minute time units. This change does not affect how providers bill for services, or how the department calculates payments. Providers should continue to bill for services in one-minute time units.

For more information, please refer to the "Anesthesia Payment Calculation" section of the current Medical Aid Rules and Fee Schedules, and to the current PB 00-05. Provider Bulletins can be viewed/downloaded from www.wa.gov/lni/hsa/hsa pbs.htm.

#### Chiropractor

Type of Service:

Use Type of Service code "C" with CPT, HCPCS and Local Codes

The department will not pay chiropractic physicians for additional codes that are not specifically allowed. Refer to the appendices in the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Chiropractic Care Visit Payment Policies

- Only **one** chiropractic care visit code is payable per day.
- Chiropractic care visit codes are payable in addition to E/M office visit codes **only when all of the following conditions are met:** 
  - The E/M service is for the **initial visit** for a **new claim**, and
  - The E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visits, and
  - Modifier -25 is added to the new patient E/M code, and
  - Supporting documentation describing the service(s) provided is included in the patient's record.

- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A to 2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- When a reopening application is filed, the services required to complete the application will be paid regardless of the insurer's action on the application:
  - When performed on the same day as completion of the reopening application (local code 1041M), an E/M visit (with -25 modifier when a chiropractic treatment code is also billed) and covered diagnostic studies (including x-rays) will be paid.
  - Treatment procedures on the same date and subsequent to the application date will only be paid if the claim is reopened, as no treatment is payable on denied reopenings (closed claims).

For more information, please refer to WAC 296-23-195 and the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

#### **CRNA**

Type of Service:

Use Type of Service code "N" with CPT, HCPCS and Local Codes.

CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are –QX and –QZ (see the "Anesthesia Modifiers" section in the current Medical Aid Rules and Fee Schedules.

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist, since they each have their own modifiers and provider account numbers. This applies to CRNAs providing solo services as well as team care.

For more information, please refer to WACs 296-23-240 and -245.

#### **Hospital ER/Professional Services**

Type of Service:

Use Type of Service code "3" with CPT and HCPCS codes

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the HCFA-1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

For more information, please refer to Chapter 296-23A "Hospitals" section in the current Medical Aid Rules and Fee Schedules.

#### **Laboratories**

Type of Service:

Use Type of Service code "3" with CPT Codes

For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

#### **Naturopath**

Type of Service:

Use Type of Service code "D" with HCPCS Codes and Local Codes

For more information, please refer to the "Specialty and Administrative Services" section and WAC 296-23 in the current Medical Aid Rules and Fee Schedule.

#### Osteopathic Physician

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT codes. E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit services may be billed in conjunction with OMT only when all the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post- service work included with OMT.
- There is documentation in a patient's record which supports the level of E/M billed.
- The E/M service is billed using the -25 modifier. E/M codes billed on the same day as OMT codes without the -25 modifier will not be paid.
- The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

#### **Outpatient Pain Management**

Type of Service:

Use Type of Service code "3" with Local Codes 2000M – 2002M

Provider must have a signed contract with the department to provide these services.

The Contractor will bill its usual and customary (U&C) fee, whether it exceeds or is below the approved maximum fees per WAC 296-20-010.

The Contractor must document in the pain clinic program records the type, frequency, length and itemized billed charges for each service provided. The Department will have access to such records upon request.

The Contractor must indicate the period covered in the bill in the box labeled 24A on the HCFA-1500 form.

#### Panel Examiner

Type of Service:

Use Type of Service "3" with CPT and Local codes

Doctors who wish to perform Independent Medical Examinations for the department or self-insurers providing coverage to workers covered under Title 51 RCW must be approved examiners. Doctors must submit a completed department application to the Provider Review and Education Unit at the Department of Labor and Industries, PO Box 44322, Olympia, WA 98504 and receive the medical director's approval. Approved examiners will be included on the department's approved examiners list.

For more information, please refer to Chapter 296-23 in the current Medical Aid Rules and Fee Schedules.

#### **Pathologist**

Type of Service:

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Use Type of Service code "3" with CPT Use Type of Service code "9" with HCPCS and Local Codes
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For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

## Physical Therapist

Type of Service:

Use Type of Service code "P" with CPT and HCPCS Codes

After 12 treatments, you must get authorization from the attending physician and the claims manager.

For more information, please refer to WAC 296-23-220 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

#### Physician and Physician Clinics

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

#### Physician Assistants

Type of Service:

Use Type of Service code "3" with CPT Codes

Use Type of Service code "9" with HCPCS and Local Codes

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultation, impairment ratings and administrative or reporting services related to worker's compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in the Provider Bulletin 99-04 and WAC 296-20-01501.

#### Podiatric Physician

Type of Service:

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Use Type of Service code "3" with CPT Codes
Use Type of Service code "9" with HCPCS and Local Codes
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For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

#### **Psychologist**

Type of Service:

Use Type of Service code "3" with CPT Codes

A psychiatrist can only be the attending physician on a claim when a psychiatric condition is the **only condition** being treated, and it has been accepted by the department. Psychologists can not be the attending physician and may not certify time loss or rate Permanent Partial Disability under our rules (WAC 296-20-210).

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors are **not covered**, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Psychological testing may be administered by staff supervised by a psychiatrist or licensed clinical psychologist. However, the interpretation of testing and preparation of reports must be performed by the psychiatrist or licensed clinical psychologist.

Please refer to WAC 296-21-270, WAC 296-21-280 and "Washington RBRVS Payment Policies" section of the current Medical Aid Rules and Fee Schedules for more information.

#### Radiologist

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

#### **RT and LT Modifiers**

HCPCS modifiers -RT (right side) and -LT (left side) do not affect payment, but may be used with CPT radiology codes (CPT codes 70010 - 79999) to identify duplicate procedures performed on opposite sides of the body.

## **Consultation Services**

CPT code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code along with the local modifier -1R.

For more information, please refer to Chapter 296-23-135, -140, -145 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

#### COMPLETING THE "HCFA-1500" FORM

Completed bill forms <u>must</u> be typed or printed and be clearly legible. All of the following boxes <u>must</u> be completed to ensure correct bill adjudication. Use the instructions below to complete the HCFA-1500 Health Insurance Claim Form.

The HCFA-1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing Labor and Industries. (The numbered boxes on the claim form are referred to as fields.) Only those fields, which pertain to billing Labor and Industries, are addressed below.

## DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

#### FIELD DESCRIPTION / INSTRUCTIONS FOR COMPLETION

- la. **INSURED'S I.D. NO.:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.
- 2. **PATIENT'S NAME:** Enter injured worker's last name, first name, and middle initial.
- 3. **PATIENT'S BIRTH DATE:** List the birth date of the worker.
- 5. **PATIENT'S ADDRESS:** Enter worker's current address.
- 11. **INSURED'S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER:** Enter worker's L&I claim number. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source which is listed below.

STATE FUND INDUSTRIAL INSURANCE Claim numbers are six digits, preceded by the letter "B, C, F, G, H, J, K, L, M, N, P, X or Y."

Send bills for State Fund claims to:

Department of Labor and Industries PO Box 44269 Olympia WA 98504-4269

CRIME VICTIMS Crime Victim Compensation Program claim numbers are either six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH or VJ".

Send bills for Crime Victims claims to:

Department of Labor and Industries Crime Victims Compensation Program PO Box 44520 Olympia WA 98504-4520 SELF-INSURANCE Self-Insurance claim numbers are six digits preceded by an "S, T or W".

Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

- 14. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and <u>must</u> be included. A worker may have several claims; therefore, it is vital the proper claim is identified and charged for services provided.
- 17. **NAME OF REFERRING PHYSICIAN:** Enter the name of the doctor referring the worker to you, if applicable.
- 17a. **I.D. NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:** This information is required if you have not listed ICD9-CM diagnosis codes in box 21 or 24E.
- 21. **DIAGNOSIS OR NATURE OF INJURY OR ILLNESS:** You may use this space to describe in more detail ICD-9 description or multiple diagnosis. You must fill in specific diagnosis on line 24E for each line item. **Designate left or right side of body, when applicable.**
- 24. ENTER ONLY 1 (ONE) SERVICE PER LINE
- 24a. **DATE OF SERVICE:** Enter numerically the month, day, and year of service (e.g., January 04, 2000 = 010400). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.

Example: Office visits made on January 3, 4, and 5 may be billed as one entry: 010300 - 010500. A "3" is entered in the units column (24g). However, office calls made on January 2, 4, and 8 should be listed on separate lines. A "1" should be entered in the units column for each date.

- 24b. PLACE OF SERVICE: Do not use the Place of Service codes listed on the back of the HCFA-1500 forms not obtained from our department. Enter required 2-digit place of service code. See list of codes in the Place of Service section of this booklet.
- 24c. **TYPE OF SERVICE:** Enter the appropriate Type of Service code. The necessary number or character is contained below. Different types of service require different Type of Service codes. Refer to provider specific instructions

Type of Service	For which Provider
$\mathbf{C}$	Chiropractors
3	Medical Services: Physicians/Physician
	Assistants, Psychologist, Osteopathic Physicians, Laboratories,
	Pathology, Radiology, Outpatient Pain Management
	Programs, Anesthesiologists
N	Advanced Registered Nurse Practitioners,
	Certified Registered Nurse Anesthetists
D	Drugless Therapist: Naturopaths
P	Physical Therapist

24d. **PROCEDURE, SERVICE, OR SUPPLY:** Identify the procedure (CPT/HCPCS/Local Code) performed. Enter only one code per line.

Please Note: The department does not publish sufficient descriptive CPT and HCPCS information to properly code provided services, since it is already available in these books. Providers and self-insurers must refer to their own copies of these books to determine the appropriate code(s) to use for billing and payment.

ATTN: All Providers – If service is listed as bundled in the fee schedule, <u>DO NOT</u> include it on the bill form. Codes that are determined as bundled by the department, will be automatically denied.

**CODE MODIFIER:** A modifier indicates a performed service or procedure has been altered by a specific circumstance. A complete list of procedure code modifiers can be found in the RBRVS & Anesthesia Section of the Fee Schedule. Indicate modifier, if applicable, after the procedure code. Example: 20816-80.

**DESCRIPTION OF SERVICES:** Describe services provided, e.g., apply long leg cast. When service is coded "unlisted" in CPT-IV, the treatment or diagnostic study must be fully described.

- 24e. **ICD-9-CM DIAGNOSIS CODE NUMBER:** One code must be recorded in this box for each line item if you do not provide referring physician ID number (in box 17a).
- 24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. (Do NOT bill negative charges)
- 24g. **DAYS OR UNITS:** Enter the total number of units, minutes, or days for the services billed on a line.
- 25. **FEDERAL TAX I.D. NUMBER:** Required. If the L&I provider account number is missing or invalid, this information helps to identify the correct provider for payment.
- 26. **PATIENT'S ACCOUNT NO.:** The number you use to identify your patient's account. This is for your convenience only.
- 28. **TOTAL CHARGES:** Total of all charges.
- 31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature may be left blank. The "DATE" is the date the bill is prepared and sent to the department or self-insurer.
- 32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:** Physical location where services were rendered.
- 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE #: Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts
Department of Labor and Industries
PO Box 44261
Olympia WA 98504-4261
Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

Indicating a new address on the bill will not change the department's record of your address and could delay payment.

**PIN** #: Enter the L&I provider account number assigned by L&I for the performing provider of service. Failure to enter your performing providers L&I provider account number will result in the bill being returned and/or denied.

**GROUP #:** If payment is to be made to a group/clinic or supervising physician (Payee) rather than the provider performing the service, you must enter the group/clinic or supervising physician's (Payee) account number designated by L&I. Include the first two characters of the group/clinic name or the first two characters of the supervising physician's last name. The name must correspond with the account number used.

This applies only to the provider groups where the group/clinic has been assigned a **main L&I provider account number (Payee)** and the members of the group have been assigned individual L&I provider account numbers.



#### **L&I HEALTH INSURANCE CLAIM FORM**

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14. DATE OF C	DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR GIVE FIRST DATE MM DD YY FREGNANCY (LMP)  15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. MM DD YY MM DD YY MM DD YY MM DD YY FROM   1 TO   1														
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19. RESERVED	MM														
	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)														
21. DIAGNOSIS	OR NATURE C	F ILLNESS OF	R INJURY.	(RELATE IT	EMS 1, 2, 3 OR 4 TO ITEM	24E BY	LII	NE) <b>i</b>	22	. MEDICAID RI	ESUBMIS	SSION			
1.1	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)														
ļ				-	<del></del>				23	. PRIOR AUTH	IORIZAT	ION NUM	BER		
2.				4.											
•															
24. A		В	С		D			Е		F	G	Н	ı	J	К
DATE(S)	OF SERVICE	PLACE OF	Type Of		OURES, SERVICES OR SUI plain Unusual Circumstance			DIAGNOSIS			Days Or	EPSDT Family	EMG	COB	RESERVED FOR
MM DD YY	MM DD YY	SERVICE	Service		/HCPCS   MODIFI			CODE		CHARGES	Units	Plan			LOCAL USE
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25. FEDERAL T	AX I.D. NUMBE	R SSN	EIN 2	6. PATIENT	S ACCOUNT NO.	27. ACCE	EPT	ASSIGNMENT?	28	. TOTAL CHAR	GE	29. AMOL	JNT PAI	D	30. BALANCE DUE
			$\neg \bot$					res No							
		<u>L</u>							\$			\$			\$
31. PHYSICIAN/SI DEGREES OR CRE					ID ADDRESS OF FACILITY IDED (If other than home or		E S	SERVICES	33	PHYSICIAN'S AND PHONE		IER'S BILL	ING NA	ME, ADD	RESS, ZIP CODE
billing instructions, that i	information contained or	this bill is consistent	-oxi V	VLINE PROV	וו סטופי נוומוו ווטווופ טו	onice)				VIND LUCINE	π				
with those instructions a	and accurate to the best	iny knowledge.)													
SIGNED		n	ATE						PII	N #		1	GRP#		
(APPROVED B				ES 8/88)										CFA-1500	
F245-127-000 (	3/92)											F	ORM OV	VCP-1500	FORM RRB1500



#### L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Anesthesiologist

	PICA					•				_					PI	ICA
1.	TION								L&I (ID)		1a. INSURED'S I		•			
	NAME (Last Nam	e, First Name	, Middle Initi	al)	3. PATIE	NT'S BIRTH [	DATE		SEX		4. INSURED'S N				ne, Middle	Initial)
Doe, Ja	ne				MM XX	DD YY XX XX	М	Г	<sub>F</sub> X							
5. PATIENT'S A	ADDRESS (No., S	Street)				NT RELATIO					7. INSURED'S AI	DDRESS	S (No., Stre	et)		
	k Creek I	_ane			Self	. П	Child		Other							
Morton				STATE		NT STATUS Marrie	ед П		Other		CITY					STATE
ZIP CODE		EPHONE (In		,	Employe	ш	ш				ZIP CODE	TI	ELEPHONE	E (Includ	de Area Co	ode)
98519		60) 00				L Studer	nt 📖	Stu	udent			(	)			
9. OTHER INSU	JRED'S NAMÉ (L	_ast Name, Fi	rst Name, M	liddle Initial)	10. IS PA	ATIENT'S COI	IOITIDI	N RE	ELATED TO:		11. INSURED'S F					₹
a. OTHE	R INSURED'S P	OLICY OR GR	ROUP NUM	BER	a. EMPL	OYMENT? (C	URREN	NT O	R PREVIOU	S)	a. INSURED'S DA	ATE OF		laim	#)	SEX
					h AUTO	ACCIDENT?		ΡI	LACE (State)	,	MM DD				М	☐ F ☐
b. OTHE	R INSURED'S D	ATE OF BIRT	Н		D. A010	YES	NO			'	b. EMPLOYER'S			DL NAM	E	
MM [	YY DC		м [	□ F □	C. OTHE	RACCIDENT					XYZ Con	npar	ıy			
c. EMPL	OYER'S NAME (	OR SCHOOL	NAME			YES	NO				c. INSURANCE F	LAN NA	ME OR PF	ROGRAI	M NAME	
d. INSUF	RANCE PLAN NA	AME OR PRO	GRAM NAM	ИΕ	10d. RE	SERVED FOR	LOCAL	L US	SE		d. IS THERE AND					ete item 9 a-d.
necessary t	OR AUTHORIZE o process this cla ignment below.									I	13. INSURED'S ( authorize paymer or supplier for ser	nt of med	dical benefi	ts to the		
SIGNED				г	DATE						SIGNED					
14. DATE OF C		ILLNESS (F	irst sympton			IT HAS HAD SAM	ME OR SI	IMILA	AR ILLNESS.	_		ENT UN	ABLE TO V	VORK II	N CURRE	NT OCCUPATION
MM DD XX   XX	XX	INJURY (Ac PREGNANC	cident) OR CY (LMP)			ST DATE	ММ	DI 	1		FROM MM	1		то		DD YY
	XXXXXX N		THER SOL		17a. I.D. NU	MBER OF RE	FERRIN	NG F	PHYSICIAN		18. HOSPITALIZ/ MM FROM		DATES TO			DD YY
	FOR LOCAL US				00000	00					20. OUTSIDE LA	1	<u> </u>	TO	\$ CH	ARGES
21. DIAGNOSIS	OR NATURE O	F ILLNESS O	R INJURY.	(RELATE IT	EMS 1, 2, 3	OR 4 TO ITEM	И 24E В	3Y LI	INE)	1	22. MEDICAID R	J NO ESUBMI	ISSION			<u> </u>
1. XXX	. XX			3.						ļ	CODE  23. PRIOR AUTH		FION NI IMI		SINAL REI	NO.
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24. A		В	С			D			Е		F	G	Н	ı	J	К
	OF SERVICE	PLACE OF SERVICE	Type Of Service	(Ex	plain Unusua	VICES OR SU	es)	S	DIAGNOS	SIS	A 0114 D 0 E 0	Days Or Units	EPSDT Family Plan	EMG	COB	RESERVED FOR
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00-0000	JUUU		$X \mid C$	Option	aı			┙,	YES L NO	)	\$ XX	$_{XX}$	\$		1	\$
DEGREES OR CR	UPPLIER SIGNATU EDENTIALS — (I cert	ify that I understand	L&I W			S OF FACILIT			SERVICES		33. PHYSICIAN'S AND PHONE	, SUPPL #	JER'S BILI	ING NA	ME, ADD	RESS, ZIP CODE
billing instructions, that	information contained on and accurate to the best of	this bill is consistent			,			•			Xxxxxx Xxxxxx, M 3112 Xxxxxx Lane	ID ∍				
											Morton, WA 9851 PIN # 0000000			X P # 000	00000	
SIGNED VV	Y AMA COUNCI	DATE XX/XX		S 8/88)											CFA-1500	(12-90)
F245-127-000				/												0 FORM RRB-1500

PLEASE
DO NOT
STAPLE
IN THIS
AREA



#### L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Chiropractor

	PICA						•		-						PI	ICA	
1.	FICA								L&I (ID)		1a. INSURED'S I.		,		OGRAMI		I
2. PATIENT'S N	,	me, First Name,	Middle Ir	nitial)		TIENT'S BIRTH D	ATE		SEX		4. INSURED'S NA	AME (Las	t Name, F	irst Nar	ne, Middle	Initial)	
Doe, Ja						XX XX XX	М		] <sub>F</sub> X		7 WOUDEDIO 45		<b>(1)</b>				
5. PATIENT'S A	,				6. PA	TIENT RELATION Spouse	Child [		Other		7. INSURED'S AL	DDRESS	(No., Stre	et)			
CITY				STATE		TIENT STATUS					CITY					STATE	
Morton	I TE	ELEPHONE (Inc	rlude Area	WA	Single	e Marrie	d	•	Other	-	ZIP CODE	I TE	LEPHONE	(Includ	le Area Co	nde)	
98519	(:	360) 000	0-000	00		oyed Full-Tir Studen	ıt 🔲	Stu	dent 🔲		11. INSURED'S F	(	)	·		ŕ	
9. OTHER INS	JRED 5 NAME	(Last Name, Fir	st mame,	widdie initial,	´	MPLOYMENT? (CI				2)	Y 00000					ζ.	
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	R INSURED'S	DATE OF BIRT	Н		b. AU	TO ACCIDENT?	⊐ №	PL	ACE (State)	-	b. EMPLOYER'S			L NAM			
	OD YY		М	☐ <sub>F</sub>	C. 01	THER ACCIDENT			II		XYZ Con	•	•				
c. EMPL	OYER'S NAME	OR SCHOOL	NAME				]				c. INSURANCE P	LAN NAI	ME OR PR	OGRA	M NAME		
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necessary t		laim. I also requ				elease of any med efits either to myse					13. INSURED'S C authorize paymen or supplier for ser	t of medi	cal benefit	s to the			
SIGNED					DATE						SIGNED						
14. DATE OF C		ILLNESS (Fi				TENT HAS HAD SAM		AILAF DD			16. DATES PATIE			ORK II		NT OCCUPAT DD YY	ION
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19. RESERVED	FOR LOCAL (	JSE									20. OUTSIDE LAI	B? ] NO	1		\$ CH.	ARGES I	
		OF ILLNESS O	R INJURY	/. (RELATE I	TEMS 1, 2	2, 3 OR 4 TO ITEM	1 24E B	Y LII	NE)		22. MEDICAID RE CODE	SUBMIS	SSION	ORIC	SINAL REI	F. NO.	
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24. A	0E 0ED //0E	В	С	55005		D	DDI JEC		E		F	G (	Н	-	J	К	
MM DD YY	OF SERVICE  MM DD Y	PLACE OF SERVICE	Type Of Service	(Ex		SERVICES OR SU sual Circumstance   MODIF	es)	5	DIAGNOSI CODE	S	\$ CHARGES	Days Or Units	EPSDT Family Plan	EMG	COB	RESERVE LOCAL	
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25. FEDERAL	 FAX I.D. NUMB	ER SSN	EIN	26. PATIENT	'S ACCO	UNT NO.	27. AC	CEPT	ASSIGNMENT?		28. TOTAL CHAR	GE	29. AMOU	INT PA	D D	30. BALANCE	DUE
00-0000	0000		X	Option	al			] \	es No		\$ XX   1	,, l	\$		ı	\$	I
31. PHYSICIAN/S DEGREES OR CR billing instructions, that with those instructions.	EDENTIALS — (I co information contained and accurate to the bes	ertify that I understand	L&I			ESS OF FACILITY other than home o			ERVICES		\$ XX   33. PHYSICIAN'S AND PHONE : XXXXXX XXXXXX, D 3112 XXXXXX Lane Morton, WA 9851 PIN # 0000000	SUPPLI # C 9 (XXX)	ER'S BILL		·	 RESS, ZIP CC	DDE
(ADDDOVED B				∩E¢ 0/00/									E/	אם אם ר	^E^_1500	/12_00\	



#### **L&I HEALTH INSURANCE CLAIM FORM**

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269
OLYMPIA WA 98504-4269
Sample: Hospital ER/Prof Svcs

	DIO.			•	Jampi	<b>C. 11</b> 05	Pita		. 01	D V C D						
1.	PICA							L&I		1a. INSURED'S I	.D. NUME	BER (F	OR PR		N ITEM 1)	
								(ID)		000-00-0	0000	(SSN	l)			
2. PATIENT'S N	NAME (Last Na	me, First Name	, Middle Ir	nitial)	3. PATIEN	NT'S BIRTH D	ATE	SEX		4. INSURED'S N				ne, Middle	Initial)	
Doe, Ja	ne					DD YY	[	<sub>F</sub> X								
5. PATIENT'S A	ADDRESS (No.	. Street)				XX XX NT RELATION	M l ISHIP TO			7. INSURED'S AI	DDRESS	(No., Stre	et)			
151 Oal	•				Self S	Spouse	Child	Other				, , , , , ,	,			
	COLCCIC	Lanc		07.475		. Ш	Crima L			OUTV						
CITY				STATE	8. PATIEN	NT STATUS				CITY					STATE	
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a OTHE	R INSLIBED'S	POLICY OR GI	SOLID NI I	MRER	a. EMPLO	YMENT? (CU	JRRENT	OR PREVIOU	JS)	a. INSURED'S D			aim	#)	SEX	
u. O II IL	IN INCORED O	OLIOT OIL OI	1001 110	WIDER	[	YES	NO			MM DD		,,,,,,,,				
h OTHE	R INSURED'S	DATE OF BIRT	Н		b. AUTO	ACCIDENT?		PLACE (State	e)	b. EMPLOYER'S	NAME O	R SCHOO	DI NAM	M F	□ F □	
SEX		D/ 112 O. D. 111	• •			YES	NO			XYZ Cor			, <u> </u>	_		
MM [	DD YY		М	$\sqcup$ <sub>F</sub> $\square$	C. OTHER	ACCIDENT?				X12 001	ιιραιι	y				
c. EMPL	OYER'S NAME	OR SCHOOL	NAME		1	YES	NO			c. INSURANCE F	PLAN NAM	IE OR PE	ROGRAI	M NAME		
d. INSUF	RANCE PLAN I	NAME OR PRO	GRAM NA	AME	10d. RESI	ERVED FOR	LOCAL I	USE		d. IS THERE AND					ete item 9 a-d.	
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12. PATIENT'S		ZED PERSON'S claim. I also req							n	<ol> <li>13. INSURED'S ( authorize paymer</li> </ol>						
	ignment below.		acot payiii	ioni oi govoniii	on bonono	cition to myoc	OI 10 ti	io party write		or supplier for ser				undereigi	ioa priyololari	
SIGNED				DA	TE					SIGNED						_
14. DATE OF C		ILLNESS (F				HAS HAD SAME							VORK II		NT OCCUPATION	1
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17. NAME OF F			OTHER SO				ERRING	PHYSICIAN		18. HOSPITALIZA			CURRE		CES DD YY	
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21. DIAGNOSIS	OR NATURE	OF ILLNESS C	INJUK1	r. (RELATE ITE	:NIS 1, 2, 3 C	JR 4 TO ITEM	1 24E BY	LINE)	]	22. MEDICAID R CODE	ESUBINIS	SION	ORIG	SINAL REI	F. NO.	
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	- •			7.												
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DATE(S)	OF SERVICE	PLACE OF	Type Of			ICES OR SU Circumstance		DIAGNO	212		Days Or	EPSDT Family	EMG	COB	RESERVED F	:OR
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31. PHYSICIAN/S DEGREES OR CR				32. NAME AND WERE PROVI				E SERVICES		33. PHYSICIAN'S AND PHONE	, SUPPLI	ER'S BILI	ING NA	ME, ADD	RESS, ZIP CODE	
billing instructions, that with those instructions	information contained	on this bill is consistent		WEINE FROVII	וו סנוו <del>פ</del> ו (וו	anan nome 0	. onice)			Pacific Laboratori	es					
man a local mondellula e	doodad to the Des	y .u.owieuge.)								3112 Xxxxxx Land Morton, WA 9851		XXX-XXX	X			
CICNED 100	<b>ΛΛΛΛΛΛΛ</b>	DATE MOVE	///							PIN # 0000000			P # 000	00000		
SIGNED VV		DATE XX/XX		CES 8/88)						<u> </u>		F	ORM H	CFA-1500	(12-90)	
F245-127-000				,											FORM RRB-15	00



#### L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

Sample: Laboratory

	PICA					~ *****	P									Р	CA I
1.									(ID)	0	00-0	0-0	000	(SSN	l)		N ITEM 1)
	NAME (Last Name <b>NC</b>	, First Name,	, Middle Ini	tial)	MM	DD YY		SEX		4.	INSURED	O'S NA	ME (Las	t Name, F	irst Nar	ne, Middle	· Initial)
					6. PATIE	NT RELATIO	NSHIP T	O INSU	RED	7.	INSURE	D'S AD	DRESS	(No., Stre	eet)		
Morton							-d [	Othe	 .r	CI	TY						STATE
ZIP CODE 98519		,		Code)	Olligio	d Full-Ti	— — me — F	Part-Tim	ie $\square$	ZII	CODE		TEI	EPHONE	E (Includ	de Area Co	ode)
9. OTHER INSU	JRED'S NAMÈ (La	ast Name, Fir	rst Name, N	Middle Initial)						) Y	000	000	(L 8	k I CI			₹
				MBER	, AUTO			DI ACE	(Stata)		MM I	DD	YY I			М	SEX F
SEX MM [	OD YY		М		,	YES ER ACCIDENT	NO ?			X	YZ C	Com	pan	y			
											YE	S	NO	If yes, re	eturn to	and comp	
necessary to accepts ass	o process this claii signment below.			ent of governr	ment benefits	s either to myse	elf or to th			au or	thorize pa supplier f	ayment or serv	of medio	cal benefit cribed be	ts to the		
MM DD XX   XX	YY	INJURY (Acc PREGNANC	cident) ÖR CY (LMP)	,	GIVE FIR	ST DATE	MM	DD	YY		FROM	MM	DD	YY	то	MM	DD YY
Xxxxxx	Xxxxxx N	/ID	THER SO				FERRING	G PHYS	SICIAN		FROM	MM	DD 		TO	MM 	DD YY
										[	☐ <sub>YES</sub>		NO	I		\$ CH.	ARGES 
		FILLNESS O	R INJURY.	•		OR 4 TO ITEM	Л 24E BY	/ LINE)	1	22	. MEDICA CODE	AID RE	SUBMIS	ISION 	ORIO	SINAL REI	F. NO.
										23	. PRIOR /	AUTHO	RIZATI	ON NUMI	BER		
24. A		В	С			D			Е		F		G	Н	1	J	K
	PATENT'S ADDRESS (No., Street)  51 Oak Creek Lane																
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DEGREES OR CR billing instructions, that with those instructions :  SIGNED WV  (APPROVED B	EDENTIALS — (I certify information contained on the and accurate to the best of the best o	y that I understand I his bill is consistent my knowledge.)	L&I V	VERE PROV		S OF FACILIT' er than home o		E SER\	/ICES	33. Pa 31. Mo	PHYSICI AND PHO cific Labo 12 Xxxxxx	IAN'S, ONE # ratories Lane 98519	SUPPLI	XXX-XXX   GR	(X RP # 000 ORM H0	00000 CFA-1500	(12-90)
F245-127-000	(3/92)													F	ORM O	WCP-150	FORM RRB-1500



#### L&I HEALTH INSURANCE CLAIM FORM

The property of the property o		_					Sa	mple:	Na	atur	01	path		OLYMPI	A WA	98504-4	4269			
2. PATIENTS INVALE LISE WARRE, FIRST NAME, Mode invals)  DOE, Jane  SERVICE STATES AND THE NAME, Mode invals)  S. PATIENTS SONTH DATE  SEX.  MAY 20 X X X X X X X X X X X X X X X X X X		PICA									_	_		1a. INSURED'S I	D. NUME	ER (F	OR PR	OGRAM I	N ITEM 1)	
DOE, JANE												(ID)		000-00-0	000	(SSN	l)			
SATING ALTONOSCIPE   STATE		•	me, First Name	, Middle II	nitial)		3. PATI	ENT'S BIRTI	H DAT	Έ	S	EX		4. INSURED'S NA	ME (Las	t Name, F	irst Nar	ne, Middle	e Initial)	
S. PATENTS ADDRESS No. SHIRED   STATE   STAT	Doe, Jar	ne								мГ		$_{F}\left[ \mathbf{X}\right]$								
MONOTION  WAS  SERVICED.**  STATE  OTHER INSUREDS INMITE (Include Area Code)  SERVICED.**  SERVI											INS			7. INSURED'S A	DRESS	(No., Stre	et)			
MORTON	151 Oak	Creek	Lane				Self	Spouse	Ch	nild	0	ther								
PRODECTION   PRINCE   Include Area Codes   98519   (360) 000-0000   PRINCE   PRINC	CITY						8. PATI	ENT STATU	IS					CITY					STATE	
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MM DD YY  C. EMPLOYER'S NAME OR SCHOOL NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME  10. RESERVED FOR LOCAL USE  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information ancocasiny to goods sharping the person's signature—1 authorize the release of any medical or other information ancocasiny to goods sharping the person's signature—1 authorize the release of any medical or other information ancocasiny to goods sharping the person's signature—1 authorize the release of any medical or other information ancocasiny to goods sharping the person's signature—1 authorize the release of any medical or other information ancocasiny to good and the person's signature—1 authorize person's signature—1 authorize person the undersigned physician or supplier to service obserted below.  SIGNED  DATE  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special at large or supplier to service obserted below.  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special at large or supplier to service obserted below.  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special at large or supplier to service obserted below.  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special at large or supplier to service obserted below.  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special at large or supplier to service obserted below.  SIGNED  ALL MESS (Finet symptomy OR 15 or Partient rule) saws on special rule) saws on special rule large or supplier should be supplied to service special saws on special rule large or supplier should be supplied to service special saws on special rule large or supplier should be supplied to service special saws on special rule large or supplier should be supplied to service special saws on special rule saws on special rule large or supplier special saws on special rule saws on s		R INSURED'S	DATE OF BIRT	Н			b. AUT				PLA	CE (State)		b. EMPLOYER'S	NAME O	R SCHOO	DL NAM			•
C. EMPLOYER'S NAME OR SCHOOL NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME  10. RESERVED FOR LOCAL USE  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  11. INSURANCE PLAN NAME OR PROGRAM NAME  12. PATIENT S. OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information recessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED  DATE  14. DATE OF COURRENT:  ILLNESS (First symptom on or incompanion of the party who accepts assignment below.  SIGNED  DATE  15. EVALUATION DATE OF COURRENT:  ILLNESS (First symptom on or incompanion or incompanion of the party who accepts assignment below.  SIGNED  DATE  16. DATE OF COURRENT:  ILLNESS (First symptom on or incompanion		D YY				$\neg$	C OTH	ш	ш		1-	I		XYZ Con	npan	y				
d. INSURANCE PLAN NAME OR PROGRAM NAME  10d. RESERVED POR LOCAL USE  1.2 PATIENTS OR AUTHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information and complete item 9 a. d.  12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information and complete item 9 a. d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information and complete item 9 a. d.  13. INSURED'S OR AUTHORIZED SIGNATURE — I authorize the release of any medical or other information and complete item 9 a. d.  14. DATE OF CHURRINT:  14. LILLESS First amount on the party who authorizes the release of any medical or other information and complete item 9 a. d.  15. IP PATIENT VIA AUTHORIZED SOR SIGNATURE — I supplied for services. described below.  16. DATES PATIENT UMBBLE TO WORK IN CURRENT OCCUPATION DELAY — I supplied for services. described below.  17. LILLESS First amount on the party who authorizes the understanded by the understand by the understanded by the und	c FMPI (	YER'S NAME	OR SCHOOL		L ⊢ F L		C. O11			NO				c INSURANCE P	I AN NAN	ME OR PE	ROGRA	M NAME		
YES   NO   If yes, sturn to and complete item 9 and.	0. 2 20	, , , , , , , , , , , , , , , , , , ,	. 011 00.1002					ш						000		0				
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process the claim. Talso request pegment of government benefits either to myself or to the party who authorize payment of release and residues below.  SIGNED  DATE  14. DATE OF CURRENT:  INLINESS, (First symptom) OR INLINEY (Academ) OR INLINEY (	d. INSUR	ANCE PLAN	NAME OR PRO	GRAM N	AME		10d. RE	SERVED FO	OR LO	CAL U	SE				_					
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#### **L&I HEALTH INSURANCE CLAIM FORM**

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION Sample: Osteopathic October WA 98504-4269

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1.	FICA							L&I (ID)		1a. INSURED'S I.		,		OGRAMÍ	N ITEM 1)
	NAME (Last Name	, First Name,	Middle Ini	itial)	3. PATIEN	T'S BIRTH DAT	E	SEX		4. INSURED'S NA	AME (Las	t Name, F	irst Nan	ne, Middle	Initial)
Doe, Ja						DD YY XX XX	м	_ <sub>F</sub> X							
	ADDRESS (No., S K Creek L					T RELATIONSI		Other		7. INSURED'S AI	DDRESS	(No., Stre	et)		
CITY				STATE	8. PATIEN	T STATUS				CITY					STATE
Morton				WA	Single	Married		Other				==			
2IP CODE 98519		60) 000		,	Employed	Full-Time	Par	rt-Time		ZIP CODE	TEI		E (Includ	le Area Co	ode)
	JRED'S NAME (La				10. IS PAT	Student IENT'S CONDI				11. INSURED'S F	,	,	R FECA	NUMBER	₹
	·			•	a. EMPLO	YMENT? (CUR	RENT C	OR PREVIOU	S)	Y 000000	) (L 8	& I C	laim	#)	
a. OTHE	R INSURED'S PO	LICY OR GF	ROUP NUM	MBER		YES	NO		,	a. INSURED'S DA	ATE OF B			м	SEX
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MM [	OD YY			□ F □		ACCIDENT?				XYZ Con	npan	y			
c. EMPL	OYER'S NAME O	R SCHOOL I	NAME	□ F □	0.0	YES	NO			c. INSURANCE P	LAN NAN	ME OR PF	ROGRAN	и NAME	
d. INSUF	RANCE PLAN NA	ME OR PRO	GRAM NA	ME	10d. RESE	RVED FOR LC	CAL US	SE		d. IS THERE AND	_				ete item 9 a-d.
	OR AUTHORIZEI									13. INSURED'S C					
	signment below.		,					, , , , , , , , , , , , , , , , , , ,		or supplier for ser					
SIGNED				DA	TE				_	SIGNED					
	YY	ILLNESS (FI INJURY (Act PREGNANCE	cident) OR CY (LMP)		5. IF PATIENT GIVE FIRS	HAS HAD SAME C T DATE MI		AR ILLNESS. D YY		MM FROM	DD	ΥΫ́	ТО	MM	NT OCCUPATION DD YY 
17. NAME OF R	EFERRING PHY	SICIAN OR C	THER SO		7a. I.D. NUMI	BER OF REFER	RRING	PHÝSICIAN			DD	YY	CURRE		DD YY
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DATE(S)	OF SERVICE	PLACE OF SERVICE	Type Of Service			ICES OR SUPP	LIES	DIAGNOS	2		Days Or Units	EPSDT Family	EMG	COB	RESERVED FOR
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00-0000	0000		$\mathbf{X}$	Optiona	ıl .			YES NO	,		, l ,	r		ı	\$
31 DUVEIGIANIE	SUPPLIER SIGNATUR	E INCLUDING	<u> </u>	R2 NAME AND	ADDRESS (	OF FACILITY W	/HERE	SERVICES		\$ XX   33. PHYSICIAN'S			ING NA	WE VUD	
DEGREES OR CR billing instructions, that	EUPPLIER SIGNATUR EDENTIALS — (I certify information contained on the best of and accurate to the best of	that I understand his bill is consistent				than home or o		GLIVICES		AND PHONE : Xxxxx Xxxxx, DO 3112 Xxxxxx Land Morton, WA 9851	# 9 (XXX)	XXX-XXX	X	·	NESS, ZIF CODE
SIGNED VV		DATE XX/XX		NEO 0/0-1						PIN # 0000000	1		P# 000		(40.00)
(APPROVED B) F245-127-000	Y AMA COUNCIL (3/92)	ON MEDICA	L SERVIC	ES 8/88)										VCP-1500	(12-90) D FORM RRB-1500

F245-127-000 (3/92)



#### L&I HEALTH INSURANCE CLAIM FORM

FORM HCFA-1500 (12-90)

FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269

**OLYMPIA WA 98504-4269** Sample: Outpatient Pain Mgmt Pgm 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) (ID) 000-00-0000 (SSN) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX DD YY Doe. Jane  $M \sqcup FX$ XX XX XX 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 151 Oak Creek Lane Spouse Child Other 8. PATIENT STATUS WA Morton Single Married Other TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) ZIP CODE Employed Full-Time Part-Time Student Student ( ) 98519 (360) 000-0000 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #) a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. OTHER INSURED'S POLICY OR GROUP NUMBER a. INSURED'S DATE OF BIRTH YES NO DD F L b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME b. OTHER INSURED'S DATE OF BIRTH YES NO SEX XYZ Company MM DD C. OTHER ACCIDENT? YES NO c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d INSURANCE PLAN NAME OR PROGRAM NAME 10d RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who authorize payment of medical benefits to the undersigned physician or supplier for services described below. accepts assignment below. SIGNED DATE SIGNED 14. DATE OF CURRENT: ILLNESS (First symptom) OR 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS TO GIVE FIRST DATE MM DD FROM 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD ΥY MM DD Xxxxxx Xxxxxx MD 0000000 FROM TO 20. OUTSIDE LAB? 19. RESERVED FOR LOCAL USE \$ CHARGES ☐ YES ☐ NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION ORIGINAL REF. NO. CODE 1. XXX XX 23. PRIOR AUTHORIZATION NUMBER 2. 1 24. DATE(S) OF SERVICE PROCEDURES, SERVICES OR SUPPLIES EMG COB OF SERVICE (Explain Unusual Circumstances) DIAGNOSIS RESERVED FOR \$ CHARGES MM DD YY MM DD YY CPT/HCPCS MODIFIER CODE LOCAL USE 03 | 01 | 01 03 | 01 | 01 xxx.xx XX 3 XXXXX  $XX \mid XX$ 1 03 | 30 | 01 04 | 28 | 01 3 XX XXXXX XXX.XX XXXXIXX 15 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE SSN EIN 29. AMOUNT PAID 00-000000 Optional ☐ YES ☐ NO  $\square$  X \$  $XXXX \mid XX$ 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES 33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE 31 PHYSICIAN/SUPPLIER SIGNATURE INCLUDING WERE PROVIDED (If other than home or office) AND PHONE # DEGREES OR CREDENTIALS - (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) Outpatient Pain Program 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX | GRP # 0000000 PIN # 0000000 SIGNED VVVVVVVV DATE XX/XX/XX
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)



#### L&I HEALTH INSURANCE CLAIM FORM

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							L			000-00-0					
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Doe, Ja	ne				MM DI	D YY X XX	м								
	ADDRESS (No., St				6. PATIENT		ISHIP TO	INSURED		7. INSURED'S A	DRESS	(No., Stre	eet)		
151 Oal	Creek L	.ane			Self Sp	ouse 🗌	Child	Other							
CITY				STATE	8. PATIENT	STATUS				CITY					STATE
Morton				WA	Single	Marrie	<sub>d</sub> П	Other							
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	(3/02)											,	JI VIVI U	1001	



#### L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION Sample: Pathology Po Box 44269 OLYMPIA WA 98504-4269

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5. PATIENT'S A	ADDRESS (No., S	treet)			6. PATIENT			INSURED	7. INSURED'S A	DDRESS	(No., Stre	eet)		
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Morton				WA		_			CITT					SIAIL
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#### L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269
Sample: Physical Therapy

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1.	PICA							L&I (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)  000-00-0000 (SSN)							
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	k Creek I	Lane				Spouse	Child	Other		CITY   STATE							
Morton				STATE		ENT STATUS Marrie	а П	Other		STATE							
ZIP CODE 98519		160) 00		,	Employ	ed Full-Tin	ne ┌── Pa	ırt-Time $\Box$		ZIP CODE TELEPHONE (Include Area Code) ( )							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED										11. INSURED'S I					₹		
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accepts ass	signment below.					or supplier for se	rvices des	scribed be	low.								
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DEGREES OR CREDENTIALS — (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge,)						OVIDED (If other than home or office)  AND PHONE #  Xxxxx Xxxxx, PT											
WILLI LI LOSE ITSTRUCTIONS &	and accurate to the DeSt	or my knowledge.)								3112 Xxxxxx Land Morton, WA 985	19 (XXX)			20000			
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(APPROVED B F245-127-000	Y AMA COUNCI (3/92)										CFA-1500 WCP-1500	(12-90) 0 FORM RRB-1500					



#### L&I HEALTH INSURANCE CLAIM FORM

SAMPLEY STANDER   SAMPLE (Late Name, First Name, Modile Initial)   SAMPLEY STANDER
2. PATIENT'S NAME (LASI Name, First Name, Middle Initial)  DOE, JANE  DOE, JANE  STATE NAME (LASI Name, First Name, Middle Initial)  7. INSURED'S ADDRESS (No., Street)  151 Oak Creek Lane  SIME DO Y MARK (LASI Name, First Name, Middle Initial)  7. INSURED'S ADDRESS (No., Street)  8. INSURED'S ADDRESS (No., Street)  8. INSURED'S ADDRESS (No., Street)  9. INSURED'S ADDRESS (No., Street)  9
DOE, JANE  S. PATENT SADDRESS (No., Street)  S. PATENT SADDRESS (No., Street)  S. PATENT SADDRESS (No., Street)  Set   Spouse   Child   Other    CITY  MORTON  WAS single   Married   Other    Set   Spouse   Child   Other
5. PATIENT'S ADDRESS (No., Sireer)  15. DATE ONLY  MOrton  WA  2P CODE    TELEPHONE (Include Area Code)   98519   (360) 000-0000  9. OTHER INSURED'S NAME (Last Name, First Name, Middle Indial)  10. IS PATIENT'S CONDITION RELATED TO:  a. OTHER INSURED'S NAME (Last Name, First Name, Middle Indial)  b. OTHER INSURED'S DATE OF BIRTH  SEX  MM
S. PATENTS ADDRESS (No., Street)  151 Oak Creek Lane  Self   Spouse   Child
CITY   STATE   MORTON   WAS INCIDENT   STATE   MORTON   STATE   MORTON   STATE   MORTON   STATE   MORTON   STATE   MORTON   State
Morton
Morton
2P CODE   GREPHONE (Include Area Code)   98519   (360) 000-0000   Employed   Full-Time   Student   Stude
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  a. OTHER INSURED'S POLICY OR GROUP NUMBER  a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. OTHER INSURED'S DATE OF BIRTH  SEX  MM
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  a. OTHER INSURED'S POLICY OR GROUP NUMBER  a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. OTHER INSURED'S DATE OF BIRTH  SEX  MM
a. OTHER INSURED'S POLICY OR GROUP NUMBER    YES   NO     NO
SEX MM DD YY  C. EMPLOYER'S NAME OR SCHOOL NAME  DATE  10. AUTO ACCIDENT?  C. OTHER ACCIDENT?  C. INSURANCE PLAN NAME OR PROGRAM NAME  J. SIGNED —  J. SIGNED —  J. SIGNED —  J. ALLINESS (First symptom) OR  J. SIGNED —  J. ALLINESS (First symptom) OR  J. ALLINESS (First symptom) OR  J. SIGNED —  J. ALLINESS (First symptom) OR  J. ALLINESS (First symptom) OR  J. SIGNED —  J. ALLINESS (First symptom) OR  J. ALLINESS (First symptom) OR  J. ALLINESS (First
b. OTHER INSURED'S DATE OF BIRTH  SEX  MM DD YY  C. EMPLOYER'S NAME OR SCHOOL NAME  DATE  101. RESERVED FOR LOCAL USE  102. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information accepts assignment below.  SIGNED  DATE  14. DATE  15. FATIENT HAS HAD SAME OR SCHOOL NAME  DATE  16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY  XX   XX   XX   XX   XX   XX   XX
SEX MM DD YY  C. EMPLOYER'S NAME OR SCHOOL NAME    C. OTHER ACCIDENT?   C. INSURANCE PLAN NAME OR PROGRAM NAME    G. INSURANCE PLAN NAME OR PROGRAM NAME   10d. RESERVED FOR LOCAL USE   G. IS THERE ANOTHER HEALTH BENEFIT PLAN?   YES   NO   If yes, return to and complete item 9 a.d.   12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.    SIGNED
C. OTHER ACCIDENT?  C. EMPLOYER'S NAME OR SCHOOL NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME  10d. RESERVED FOR LOCAL USE  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO If yes, return to and complete item 9 a.d.  11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information accepts assignment below.  11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information accepts assignment below.  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information accepts assignment below.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information accepts assignment below.  14. DATE OF CURRENT:  ILLNESS (First symptom) OR  INJURY (Accident) OR  PREGNANCY (LMP)  IT, NAME OR PREFERRING PHYSICIAN  INJURY (Accident) OR  PREGNANCY (LMP)  IT, NAME OR PREFERRING PHYSICIAN  O0000000  17. NAME OR PREFERRING PHYSICIAN  O0000000  18. HOSPITALIZATION DATES TO CURRENT SERVICES  MM DD YY MM DD YY  FROM TO
C. INSURANCE PLAN NAME OR PROGRAM NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME  10d. RESERVED FOR LOCAL USE  12. PATIENT'S OR AUITHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information accepts assignment below.  12. PATIENT'S OR AUITHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information accepts assignment below.  12. PATIENT'S OR AUITHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information accepts assignment below.  13. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  14. DATE  15. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  15. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  15. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  16. INSURANCE PLAN NAME OR PROGRAM NAME  17. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  16. INSURED'S OR AUITHORIZED PERSON'S SIGNATURE—I authorize the release of any medical or other information accepts assignment below.  16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD Y
YES NO   If yes, return to and complete item 9 a -d.
YES NO   If yes, return to and complete item 9 a -d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE — I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED
necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED
accepts assignment below.  SIGNED
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14. DATE OF CURRENT:
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XXXXXX
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)  1. XXX . XX  2.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)  1. XXX . XX  2.
1. XXX . XX  2.
2.
24. A B C D E F G H I J K  DATE(S) OF SERVICE PLACE OF SERVICE SERVICE SERVICES OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS CODE SCHARGES  DIAGNOSIS CODE SCHARGE
DATE(S) OF SERVICE  MM DD YY MM DD YY  MM DD YY MM DD YY  MX 3  Days CF Family Pian EMG  COB  RESERVED FOR LOCAL USE  CPT/HCPCS   MODIFIER  XXX.XX  XX   XX   XX   XX   XX   XX
DATE(S) OF SERVICE  MM DD YY MM DD YY  MM DD YY MM DD YY  MX 3  Days CF Family Pian EMG  COB  RESERVED FOR LOCAL USE  CPT/HCPCS   MODIFIER  XXX.XX  XX   XX   XX   XX   XX   XX
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03   01   01   03   01   01   XX   3   XXXXX   XX   XX   XX   XX
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
00-000000
S XX XX S S
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CRED ENTIALS — (I centify that I understand L&I billing instructions, that information contained on this bill is consistent  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #  XXXXXX XXXXXX, MD/Medical Clinic
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CRED ENTIALS — (I) centify that I understand Lai billing instructions and accurate to the best of my knowledge.)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #  Xxxxx Xxxxxx, MD/Medical Clinic 3112 Xxxxxx Xxxxxx Lane
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CRED ENTIALS — (I centify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #  Xxxxx Xxxxxx, MD/Medical Clinic 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXXX PIN # 0000000   GRP # 0000000
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CRED ENTIALS — (I) centify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PROVIDED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #  Xxxxx Xxxxxx, MD/Medical Clinic 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXXX



(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)

F245-127-000 (3/92)

#### L&I HEALTH INSURANCE CLAIM FORM

FORM HCFA-1500 (12-90)

FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269

**OLYMPIA WA 98504-4269** Sample: Physician Assistant 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) L&I (ID) 000-00-0000 (SSN) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial) DD YY XX XX Doe. Jane  $M \sqcup FX$ XX 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 151 Oak Creek Lane Spouse Child Other 8. PATIENT STATUS WA Morton Single Married Other TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) ZIP CODE Employed Full-Time Part-Time Student Student ( ) 98519 (360) 000-0000 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L & I Claim #) a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. OTHER INSURED'S POLICY OR GROUP NUMBER a. INSURED'S DATE OF BIRTH YES NO DD F L b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME b. OTHER INSURED'S DATE OF BIRTH YES NO SEX XYZ Company DD MM C. OTHER ACCIDENT? YES NO c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? d INSURANCE PLAN NAME OR PROGRAM NAME 10d RESERVED FOR LOCAL USE YES NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who authorize payment of medical benefits to the undersigned physician or supplier for services described below. accepts assignment below. SIGNED DATE SIGNED 14. DATE OF CURRENT: ILLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Τ<u>Ο</u> MM DD GIVE FIRST DATE MM DD FROM 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 18. HOSPITALIZATION DATES TO CURRENT SERVICES 17a. I.D. NUMBER OF REFERRING PHYSICIAN MM DD FROM | ΥY MM DD 0000000 Xxxxxx Xxxxxx MD то 20. OUTSIDE LAB? 19. RESERVED FOR LOCAL USE \$ CHARGES YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION ORIGINAL REF. NO. CODE 1. XXX XX 23. PRIOR AUTHORIZATION NUMBER 2. 1 24. DATE(S) OF SERVICE PLACE OF SERVICE PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)
PPT/HCPCS | MODIFIER EMG COB DIAGNOSIS RESERVED FOR \$ CHARGES MM DD YY MM DD YY CPT/HCPCS CODE LOCAL USE 03 | 01 | 01 03 | 01 | 01 XX XXXXX xxx.xx 3 |XX| $XX \mid XX$ 1 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT 28. TOTAL CHARGE 29. AMOUNT PAID YES NO 00-000000 Optional  $\square X$ \$ XX | XX | \$ | | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES 31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING WERE PROVIDED (If other than home or office) AND PHONE # DEGREES OR CREDENTIALS - (Lcertify that Lunderstand L&L billing instructions, that information contained on this bill is consister with those instructions and accurate to the best of my knowledge.) Xxxxx Xxxxx, PA 3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX | GRP # 0000000 PIN # 0000000 SIGNED VVVVVVVV DATE XX/XX/XX



#### L&I HEALTH INSURANCE CLAIM FORM

	PICA				Sa	mple: F	oa1	lai	tric Pn	ys					DI	CA	-		
1.	FICA								L&I		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)								
									(ID)		000-00-0	000	(SSN	)					
2. PATIENT'S N	NAME (Last Name	e, First Name,	Middle I	nitial)	3. PATIE	NT'S BIRTH D	ATE		SEX		4. INSURED'S NA				ne, Middle	Initial)			
Doe, Jai	ne				MM			Г	FX										
•	ADDRESS (No., S	Street)				XX XX NT RELATION	M				7. INSURED'S ADDRESS (No., Street)								
	k Creek L	,				Spouse (			Other										
	CICCK L	Laric				. П			Other										
CITY				STATE	-	NT STATUS					CITY					STATE			
Morton				WA	Single	Marrie	d $\square$		Other										
ZIP CODE		EPHONE (Inc		,	Employe	 d Full-Tim		Pari	t-Time —		ZIP CODE TELEPHONE (Include Area Code)								
98519		60) 000				Student	t 🗀	Stu	ıdent 📖		( )								
9. OTHER INSU	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO										11. INSURED'S P					1			
a. EMPLOYMENT									R PREVIOU	S)	Y 000000				#)				
a. OTHE	R INSURED'S P	JMBER		☐ YES ☐	ON				a. INSURED'S DATE OF BIRTH SEX										
					YES NO					1	1			М	∐ <sub>F</sub> ∐				
	R INSURED'S DA	ATE OF BIRTI		b. AUTO	ACCIDENT?	ON [	ы	LACE (State)		b. EMPLOYER'S			L NAM						
SEX MM [	DD YY						J		,,		XYZ Con	npan	У						
 	 OYER'S NAME C	D COLLOCI A		1 LJ F L	C. OTHE	R ACCIDENT?	T NO				- INCLIDANCE D		4E OD DD	0000	4 514 545				
C. EMPL	OYER'S NAME C	OR SCHOOL I			C. INSURANCE PLAN NAME OR PROGRAM NAME														
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d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE											d. IS THERE AND	_				ete item 9 a-d.			
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12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who											<ol> <li>13. INSURED'S C authorize paymen</li> </ol>								
	signment below.	iiii. i aiso requ	nent of govern	cities to myse	11 01 10	uic	party write		or supplier for ser				undersigi	ica priysician					
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MM DD XX   XX	YY	INJURY (Acc		GIVE FIR	ST DATE	MM	DI	D YY		FROM MM	DD	YY	то	MM	DD YY				
17. NAME OF F	REFERRING PHY	SICIAN OR O	OURCE	17a. I.D. NUI	MBER OF REF	ERRIN	IG F	PHYSICIAN		18. HOSPITALIZA	TION DA	TES TO		NT SERVI	CES				
Xxxxxx	Xxxxxx N	ΛD		000000	00					FROM MM		YY	то	MM	DD YY				
	FOR LOCAL US										20. OUTSIDE LAI		-	10	   \$ CH/	ARGES			
											YES	NO							
21. DIAGNOSIS	OR NATURE O	F ILLNESS O	R INJUR	Y. (RELATE IT	EMS 1, 2, 3	OR 4 TO ITEM	24E B	Y LI	INE)		22. MEDICAID RE		SION						
				,						,	CODE			ORIG	INAL REF	. NO.			
1. XXX	. XX			3.					•		23. PRIOR AUTHORIZATION NUMBER								
2.				4.															
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24. A		В	С		-	-			E		F	G	н	ı	J	K			
DATE(S)	OF SERVICE	PLACE OF SERVICE	Type			VICES OR SUF I Circumstance:		6	DIAGNOS	19		Days Or Units	EPSDT Family	EMG	СОВ	RESERVE	) FOR		
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-	TAX I.D. NUMBEI	R SSN	EIN	26. PATIENT	'S ACCOUN	TNO.	27. AC	CEPT	ASSIGNMENT?		28. TOTAL CHAR	GE :	29. AMOU	INT PAI	D	30. BALANCE	DUE		
00-0000	0000		X	Option	al			],	YES NO	,									
											\$ XX   Z	xx :	\$		1	\$	ı		
31. PHYSICIAN/S	UPPLIER SIGNATUI	RE INCLUDING				OF FACILITY			SERVICES		33. PHYSICIAN'S	SUPPLI	ER'S BILL	ING NA	ME, ADD	RESS, ZIP CO	DE		
	EDENTIALS — (I certi information contained on		.&I	WERE PROV	OVIDED (If other than home or office)  AND PHONE #  Xxxxx Xxxxx, DPM														
with those instructions a	and accurate to the best o	3112 XXXXXX Lane																	
											Morton, WA 9851 PIN # 0000000			X P # 000	0000				
									ı GR	. # 000	0000								
SIGNED WWWWWW DATE XX/XX/XX  (APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)  F245-127-000 (3/92)															FA-1500	(12-90) ) FORM RRB-			



#### L&I HEALTH INSURANCE CLAIM FORM

	PICA						S	amp	le: F	syc	ch	ologis	t	OLTIVIF	A WA	90004-4	+209	ь	CA T		
1.	FICA											L&I		1a. INSURED'S		•		OGRAMI	N ITEM 1)		
2. PATIENT'S N	NAME (Last N	lamo Eire	t Namo	Middle Ir	vitial)		2 DA	TIENT'S E	DIDTU N	ATE.	L	SEX		000-00-0	) <u>))</u>	(SSN	) iret Nor	no Middle	Initial		
Doe, Ja	•	iaine, i na	st ivailie,	ivildale ii	iiliai)		J. FA		YY	AIL	_			4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S A		o Street	1					X XX		M ISHIP	TOI	F X		7. INSURED'S ADDRESS (No., Street)							
151 Oal							Self	Spous	_	Child		Other		7. 114001125 071	DDINEO	o (110., out	Ot)				
CITY						STATE	8. PA	TIENT ST	ATUS	l				CITY STATE							
Morton						WA	Single		Marrie	а□		Other									
ZIP CODE		TELEPHO	,			e)	Emplo		Full-Tim					ZIP CODE TELEPHONE (Include Area Code)							
98519	98519 (360) 000-0000 Employed Full-Time Student Studen										11. INSURED'S POLICY GROUP OR FECA NUMBER										
													6/						`		
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. EMPLOYMENT? (CURRENT OR PREVIOUS)				3)	Y 000000 (L & I Claim #)  a. INSURED'S DATE OF BIRTH  SEX									
						h All	YES NO MM DD YY						М	F							
SEX	R INSURED'S	S DATE C	OF BIRTI	1			5.710		ES	NO			'	b. EMPLOYER'S			DL NAM	E			
MM [	DD YY			М		F $\square$	C. OT	HER ACC	CIDENT?	, No				XYZ Cor	•	-					
c. EMPL	OYER'S NAM	IE OR SC	HOOL	NAME				Ш	123 L	] 140				c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSUF	RANCE PLAN	NAME (	OR PRO	GRAM NA	AME		10d. F	RESERVE	D FOR I	LOCAL	. US	SE		d. IS THERE AN	OTHER	HEALTH B	ENEFIT	PLAN?			
														YES	NO	If yes, re	eturn to	and compl	ete item 9 a-d.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who											13. INSURED'S authorize payme										
	signment belo			,		9			,			pa,		or supplier for se					,		
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XX   XX	XX	PRE	EGNÀNC	Y (LMP)								I		FROM MN			то	1	DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NI XXXXXX XXXXXX MD 00000									OF REF	ERRIN	IG P	PHYSICIAN		18. HOSPITALIZ MN			CURRE		CES DD YY		
XXXXXX XXXXXX MD  19. RESERVED FOR LOCAL USE							000	000						FROM 20. OUTSIDE LA	 \B?		ТО	 \$ CH.	 ARGES		
														☐ <sub>YES</sub> ☐	] <sub>NO</sub>	1			1		
21. DIAGNOSIS	S OR NATUR	E OF ILLI	NESS O	R INJURY	/. (REI	LATE ITE	MS 1, 2,	3 OR 4 T	ГО ІТЕМ	24E B	ΥLI	NE)		22. MEDICAID R CODE	ESUBM	ISSION	ORIO	SINAL REI	NO.		
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2.	_ •				4.			_						23. PRIOR AUTHORIZATION NUMBER							
24. A			В	С				D				Е		F	G	Н	ı	J	К		
DATE(S)	OF SERVICE		PLACE	Type Of	P			ERVICES			S				Days	EPSDT Family	EMG	COB			
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	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?									28. TOTAL CHAP	GE	29. AMOL	INT PAI	D	30. BALANCE DUE						
00-0000000 □ 🗓 Optional □ YES□ NO								)	\$ XX	XX	\$			\$							
31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING 32. NAME AND ADD											SERVICES		33. PHYSICIAN'S	S, SUPPI		ING NA	ME, ADD	RESS, ZIP CODE			
DEGREES OR CREDENTIALS — (Learlify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)						/IDED (If other than home or office)  AND PHONE #  Xxxxx Xxxxx, PhD															
, , , , , ,						3112 Xxxxxx Lane Morton, WA 98519 (XXX) XXX-XXXX PIN # 0000000   GRP # 0000000															
SIGNED VVVVVVVVV DATE XX/XX/XX  (APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)													PIN # 000000	<u> </u>							
(APPROVED B F245-127-000		NCIL ON	MEDICA	L SERVI	CES 8/	/88)												CFA-1500 WCP-150	(12-90) FORM RRB-1500		



#### L&I HEALTH INSURANCE CLAIM FORM

						Co	mnla.	D	ndin	logy	0	LYMPI	A WA	98504-4	1269			
		Sample: Radiology				1 4- INO	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)											
1.										L&I (ID)	000-	00-0	0000	(SSN	l)		,	
2. PATIENT'S N	,	me, First Name,	Middle Ini	tial)	3	B. PATIE	NT'S BIRTH	H DA	ΤE	SEX	4. INSU	RED'S N	AME (Las	t Name, F	irst Nar	ne, Middle	e Initial)	
Doe, Ja	ne					MM	DD YY		м□	FX								
5. PATIENT'S A	ADDRESS (No.,	, Street)			6		NT RELATI				7. INSU	RED'S A	DDRESS	(No., Stre	et)			
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER						R					
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31. PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS — (I certify that I understand L&I WERE PROVIDED										SERVICES	AND	PHONE	#	EK S BILL	ING NA	AME, ADD	RESS, ZIP CC	υDΕ
billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.)											Jones Ra 3112 Xx							
												VA 985	19 (XXX)		X P # 000	10000		
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(APPROVED B F245-127-000		IL ON MEDICA	L SERVIC	ES 8/88)												CFA-1500 WCP-150	(12-90) 0 FORM RRB	-1500

## **REBILLS**

REBILLS should be submitted when:

Your TOTAL BILL has been denied.

Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be <u>received</u> at the department within one year of the date the final order was issued which reopened or allowed the claim or diagnosis.

A rebill should be identical to the original bill: same charges, codes and dates of service. Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

## **ADJUSTMENTS**

A "Providers Request for Adjustment" form (F245-183-000) should be submitted to correct an incorrect field on a bill that has already processed and partially paid.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers mane and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

Claim #	Name	I	Patient Acct#	ICN	Service From		Unit	Procedure	Billed Charge
P000000	XXXXXXX	X	XXXXXXXXX	00103625045000200	121300	121700	1	XXXXX	XX.XX

In the body of the form (field 8) complete only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

#### **EXAMPLE:**

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on adjustments initiated by the department:

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a decreased adjusted payment must be made in writing within 20 days of receipt of payment.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request should be submitted with the request.

#### Note:

DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on next page)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., \$100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., \$125.00). The "adjusted payment" will be paid in the warrant (e.g., \$25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., \$100.00).

If the original payment is being recouped, the total amount allowed for the bill will be reported (e.g., \$0.00). The "adjusted payment" will recoup the original amount of the bill.

NO STAPLES IN BAR CODE AREA



Department of Labor and Industries PO Box 44267 Olympia WA 98504-4267

# PROVIDER'S REQUEST FOR ADJUSTMENT

DO NO WRITE SPACE	E IN >						ECK® INE	PARTIA UNDERI	OVERPAYM AL OVERPAY PAYMENT  type or print	MENT	-		
		ORIO	GINA	L REMMITTANCE AD	VICE		INSTRU	UCTIONS AR	RE ENCLOS	SED			
	ERS NAME (Last, First, Middle)					2) CLAIM NUMBER ON REMIT ADVICE 3) CORRECT CLAIM NUMBER							
4) PROVII	DER NAME AND ADDRESS					5) ICN NUMBER O		ADVICE					
						6) PROVIDER NUM							
						7) PAYEE NUMBER							
CC	MPLETE ONLY	THC	SE L	LINE ITEMS PAID/D	ENIED I		ENTER O			NFORM	ATION		
8) Line Item #	a) From/to Date of Service or Covered Dates	b) P O S	c) T O S	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth Number	Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description		
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9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER
		( )

14

#### ADJUSTMENT REQUEST FORM

#### THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----

Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

Cashiers Office Department of Labor and Industries PO Box 44835 Olympia WA 98504-4835

PARTIAL OVERPAYMENT ---

A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT -----

If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:

Bills returned to you by the Department **OR** totally denied bill. New bill must be submitted.

#### INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number). Attach a copy of remittance advice and original bill.

- 1. WORKER'S NAME: Clearly print injured worker's full name.
- 2. CLAIM NUMBER ON REMITTANCE ADVICE: Enter the 7-digit number found in the Claim Number column on the remittance advice.
- 3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
- **4. PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
- **5. ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
- **6. PROVIDER NUMBER:** Enter the Labor and Industries provider account number for the provider of service as it appears on the remittance advice.
- 7. PAYEE NUMBER: Enter the Labor and Industries payee provider account number if payee was **different** than the provider of service.
- **8. SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
  - **a.** From/to Date of Service or Covered Dates: Date of Service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
  - **b.** Place of Service: (POS) Two digit code identifying the place of service was performed.
  - c. Type of Service: (TOS) One digit code identifying the general type of service performed.
  - d. Procedure Code/Revenue Code/NDC: Identify correct procedure, hospital service or national drug code.
  - e. Code Mod: Modifier used to identify special circumstances for a service or procedure.
  - **f. ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
  - **g.** Tooth Number: For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
  - **h.** Charge: Total of charges for services provided this line.
  - i. Days/Units/Quantity: Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
  - **Days Supply:** Total number of days a prescription is intended to cover.
  - **k. Description:** Describe procedure or service.
- **9. OTHER REMARKS/JUSTIFICATION/SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.

SAMPLE PAGE BLMC8000-R001 AS OF 03/28/2001

## DEPARTMENT OF LABOR AND INDUSTRIES OLYMPIA, WASH 98504

REMITTANCE ADVICE

007589

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER 0000000 REMIT ADVICE # XXXXXX	VARRANT REGISTER NUMBER	60048 DATE	03/30/2001	PAGE X			
CLAIM NAME I PATIENT ICN NUMBER ACCT/RX NUMBER	SERVICE DATES UNI FROM TO OF SVO	REVENUE	BILLED CHARGES	ALLOWED	TAX OR NON- COVD CHARGES	PAYABLE	EOB CODES
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#### TYPE OF SERVICE CODES:

C	Chiropractic Services	Р	Physical Therapy
D	Drugless Therapeutics	V	Vocational Services
I	Inpatient	3	Medical Services
N	Nurse Practitioner Services	4	Dental
O	Outpatient	9	AncillaryServices
			(attendant, equipment, glasses)

#### PLACE OF SERVICE CODES:

- 11. Office
- 12. Patient's Home
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Military Trmt Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance Land
- 42. Ambulance Air or Water
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trtmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehab Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility

#### Directory:

#### FIELD SERVICE OFFICES

Aberdeen: 415 West Wishkah, Suite 1B

Aberdeen WA 98520-0013

(360) 533-8200

Okanogan: 1234 2<sup>nd</sup> Avenue S

Okanogan WA 98840-0632

(509) 826-7345

Bellevue: 616 120<sup>th</sup> Avenue NE, Suite C201

Bellevue WA 98005-3037

(425) 990-1400

Port Angeles: 1605 East Front Street, Suite C

Port Angeles WA 98362-4628

(360) 417-2700

Bellingham: 1720 Ellis Street, Suite 200

Bellingham WA 98225-4600

(360) 647-7300

Pullman: 1250 Bishop Blvd SE, Suite G

PO Box 847

Pullman WA 99163-0847

(509) 334-5296 1-800-509-0025

Bremerton: 500 Pacific Avenue, Suite 400

Bremerton WA 98337-1904

(360) 415-4000

Seattle: 300 W Harrison Street

Seattle WA 98119-4081

(206) 281-5400

Colville: 298 South Main, Suite 203

Colville WA 99114-2416

(509) 684-7417 1-800-509-9174 Spokane: 901 N Monroe Street, Suite 100

Spokane WA 99201-2149

(509) 324-2600 1-800-509-8847

East Wenatchee: 519 Grant Road

East Wenatchee WA 98802-5459

(509) 886-6500 1-800-292-5920 Tacoma: 950 Broadway Suite 200

Tacoma WA 98402-4453

(253) 596-3800

Everett: 729 100<sup>th</sup> St SE

Everett WA 98208-3727

(425) 290-1300

Tukwila: 12806 Gateway Drive

PO Box 69050

Seattle WA 98168-1050

(206) 248-8240

Kennewick: 4310 W 24<sup>th</sup> Ave

Kennewick WA 99338-1992

(509) 735-0100 1-800-547-9411 Tumwater: PO Box 44851

7273 Linderson Way SW Olympia WA 98504-4851

(360) 902-5799

Longview: 900 Ocean Beach Hwy

Longview WA 98632-4013

(360) 575-6900

Vancouver: 312 SE Stonemill Dr, Suite 120

Vancouver WA 98684-3508

(360) 896-2300

Moses Lake: 3001 W Broadway Ave

Moses Lake WA 98837-2907

(509) 764-6900

Walla Walla:

1815 Portland Avenue, Suite 2

Walla Walla WA 99362-2246

(509) 527-4437

Mount Vernon: 525 E College Way, Suite H

Mount Vernon WA 98273-5500

(360) 416-3000

Yakima:

15 W Yakima Avenue, Suite 100

Yakima WA 98902-3480

(509) 454-3700 1-800-354-5423

\* indicates Regional Office (Revised 7/30/2001)